APPLICATION for Health Benefits for Persons with Breast or Cervical Cancer

When a woman learns she may have breast or cervical cancer, she needs treatment right away and she should not have to worry about how to pay for it. Now the state of Illinois has expanded health insurance for low-income women with breast or cervical cancer or certain precancerous cervical conditions. There are no premiums for this coverage. The IBCCP (Illinois Breast and Cervical Cancer Program) and Health Benefits for Persons with Breast or Cervical Cancer work together to cover the medical services a woman in this situation needs.

Section 1 – To be completed by the medical provider. *Please print*.

Patient Name	Date of Birth

Medical Provider Name	Provider Address

Contact at Provider's Office _____ Phone ( ) _____

Fax ( ) _____ E-mail _____

Diagnosis supported by pathology report:

- ❑ Breast Cancer
- ❑ Cervical Cancer
- ❑ Cervical Intraepithelial Neoplasia, grade III (CIN III)
- ❑ Severe dysplasia of the cervix
- ❑ High-Grade Squamous Intraepithelial Lesion (HGSIL)
- ❑ Atypical glandular cells of undetermined significance (AGUS) with a suspicion of adenocarcinoma in situ

If none of the above, stop. Patient does not qualify.

Date of Diagnosis

Date Screening Began – if known

Circle the patient's income, to the best of your knowledge.

If income is higher than levels in the table, stop. Patient does not qualify.

Household size	Total Household Income		
	Weekly	Monthly	Annual
1	$491	$2,127	$25,525
2	$658	$2,852	$34,225
3	$825	$3,577	$42,925
4	$993	$4,302	$51,625
5	$1,160	$5,027	$60,325
6	$1,327	$5,752	$69,025
7	$1,495	$6,477	$77,725
8	$1,662	$7,202	$86,425
Each addtn'l add	$167	$725	$8,700

If patient's diagnosis and income fall within program criteria, please read the following, sign and date below, assist the patient to complete Section 2 and submit the application as described on the next page.

Submission of this application does not guarantee that the patient named above will qualify for Health Benefits for Persons with Breast or Cervical Cancer, nor does it absolve medical providers of any legal or ethical responsibility to their patients.

_____ _____

Signature of Medical Provider Date

_____

Print name

Medical Provider's Checklist

✓ Assist the patient to complete Section 2 and collect copies of necessary documents.

✓ Check to make certain Section 1 and Section 2 are completed and signed.

✓ Attach the following documents to the application:
- Pathology report supporting the reported diagnosis
- *Cornerstone Informed Consent Form* signed by the **patient** and a **witness**
- Proof of patient's age
- Copy of patient's insurance cards, if applicable
- Proof of all income reported by the patient
- Proof of patient's citizenship or immigration status

✓ Submit the application completed as much as possible and required attachments to the IBCCP Lead Agency serving the patient's county/community. **Applications submitted without the applicant's name, address, signature, a pathology report and signed *Cornerstone Informed Consent Form* will not be processed.**

✓ To find where to submit applications for your county/community, please contact the Illinois Department of Public Health at 217-524-6088 to be directly connected/referred to the respective IBCCP Lead Agency in your area, or visit the website at www.cancerscreening.illinois.gov and find the interactive Illinois map under **IBCCP Offices** tab.

Review Process

The IBCCP Lead Agency will review the application to decide whether the applicant meets the qualifying criteria for age, insurance status, income and diagnosis. The IBCCP Lead Agency will forward to Healthcare and Family Services (HFS) only applications that meet these qualifying criteria. The Lead Agency will notify the applicant and medical provider of its decision. Applications that do not meet these criteria will be immediately returned to the referring medical provider.

If the application meets the qualifying criteria for age, insurance status, income and diagnosis, the Lead Agency will send it to HFS for the final determination of whether the applicant qualifies for Health Benefits for Persons with Breast or Cervical Cancer. HFS will notify the applicant, medical provider and the Lead Agency of its decision.

Become a Participating Provider

Persons who qualify for Health Benefits for Persons with Breast or Cervical Cancer are covered for a full array of medically necessary services provided by medical providers enrolled to participate with HFS. If you are not currently enrolled with HFS, please call 1-217-782-0538 or visit the HFS website at www.hfs.illinois.gov/enrollment/ for information about the program and medical provider enrollment documents. If your patient qualifies, you may receive payment for services already rendered.

Section 2 – To be completed by the applicant. *Please print.*

If you need help to complete these questions, ask your medical provider or call the Women's Health-Line at 1-888-522-1282 to find an agency near you that can help. If you use a TTY, call 1-800-547-0466. The call is free.

Last name	First name	
Maiden Name or other legal name	Sex ❑ Male ❑ Female	Social Security Number _____-_____-_____
Date of Birth	★ Send a copy of a birth certificate, driver's license or other document that proves your age.	

Mailing address City State Zip

County you live in	**Home Phone** ( )	**Other phone** ( )

If you do not have a phone and we can reach you by calling someone else tell us who.
Name Phone
( )

Years of education completed	Are you pregnant now? ❑ Yes ❑ No	Marital Status/Relationship ❑ Never Married ❑ Married ❑ Widowed ❑ Divorced ❑ Separated ❑ Other_____

If you are married, please complete the following even if your spouse is not living with you.

Name of Spouse:_____ Social Security Number: _____ - _____ - _____

Name of Spouse's Employer (if employed): _____

Language Preference ❑ English ❑ Spanish ❑ Other _____	Are you of Hispanic Origin? ❑ Yes ❑ No

Race - Mark **all** that apply.

❑ White ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander
❑ American Indian or Alaska Native ❑ Asian ❑ Unknown

If Asian, please tell us your subgroup:

❑ Chinese ❑ Japanese ❑ Filipino ❑ Indian ❑ Korean ❑ Vietnamese ❑ Other

1. Health Insurance

Do you have or have you had health or hospital insurance including Medicare any time in the last 3 months? ❑ Yes ❑ No

If your insurance was cancelled, tell us the date. _____ Do you have insurance just for cancer? ❑ Yes ❑ No

★ If you have any form of health insurance, send a copy of the front and back of your insurance card with your application.

2. Income from Employment

What is your total income from employment? Include all income before taxes including tips. If you are married, list the combined amount earned by you and your spouse.

$_____ per ❑ week ❑ month ❑ year

★ Send a copy of 2 pay stubs, a W2 form, an income tax return or any other documents to prove your earnings from employment.

Section 2 - *continued*

3. Other Income

Does anyone in your family receive money other than what you earn from a job? ❑ Yes ❑ No

This could be Social Security, child support, spouse support, income from rental property, unemployment benefits, pensions or trust income. If yes, complete the following.

Name of person who gets the money	Gross Monthly Amount	From where

Send a copy of each payment received in the last 30 days for each source of other income.

4. Household Size

How many people are supported by the income you listed for question 2 and 3?
Count your children or step-children younger than 19, your spouse if you are married, and yourself. _____

Tell us the names and ages of the people you counted and how they are related to you.

Name	Age	Relationship

5. Support Payments

Do you or does anyone listed above pay child support or spousal support? ❑ Yes ❑ No

If yes, how much is paid each month? _____

Section 2 - *continued*

6. Question about U.S. Citizenship

Are you a U.S. citizen? ❑ Yes ❑ No If yes, tell us where you were born. If no, go to question 7.

Place of birth – City _____ State _____

Send a copy of a U.S. passport, Certificate of Naturalization (N-550 or N-570), Certificate of Citizenship (N-550 or N-561). If you do not have one of these documents, send a copy of one document from each of the following lists to prove your citizenship and identity.

Citizenship	Identity
• Certified copy of a birth certificate from the state or county where you were born • Final Adoption Decree • Official military record that shows your place of birth • Papers showing you were employed by the U.S. government before 1976.	• Driver's license or State issued ID card • School ID • U.S. military ID • U.S. military dependent card • Other government ID issued by a city, county, or U.S. state.

If you do not have one of these citizenship or identity documents, you can send in your application without them, but you must try to get them.

You can get birth certificates from the state or county where you were born. You will need to list your name on your birth certificate, your date of birth, where you were born and your parents' names to apply for an official copy of your birth certificate. You may have to pay for an official copy.

If you were born in Illinois, you can find out where to get your birth certificate from the county where you were born at www.idph.state.il.us/vitalrecords/countylisting.htm or you can get your birth certificate from the state by calling the Illinois Division of Vital Records, M – F, 8:30 a.m. – 4:00 p.m. at 217-782-6553, or applying over the Internet at www.idph.state.il.us/vitalrecords.

If you were born in a different state, you can find out how to apply for your birth certificate from the National Center for Health Statistics. Call 1-866-441-6247. The call is free. You can also visit www.cdc.gov/nchs.

If you cannot get documents to prove you are a U.S. citizen or your identity, call the Health Benefits Hotline at 1-800-226-0768. If you use a TTY, call 1-877-204-1012. The call is free. There may be other documents you can use.

7. Immigration

If you are not a U.S. citizen, tell us your Alien Registration Number _____

Send a copy of one of the items listed below as proof of your Alien Registration Number.

- Alien Registration Receipt Card, Permanent Resident Card or Green Card.
- Passport with the following stamps or attachments: Arrival-Departure Record (I-94) including the stamp showing status, or Resident Alien Form (I-551) or Temporary Resident Card (I-688).
- A court-ordered notice for asylees.
- Other proof of lawful immigration status.

Only the person applying for Health Benefits for Persons with Breast or Cervical Cancer needs to provide proof of legal immigration status. The state will not check the immigration status of anyone else in the household.

Section 2 – continued

Read and Sign

Read carefully, then sign and date the application below.

- Be sure to answer the questions correctly. HFS (Healthcare and Family Services) may check all information on this form. You must help us if we ask you to prove that your information is right.
- We will keep what you tell us private as required by law.
- By signing below, you give your healthcare providers permission to share information about you including your medical condition with IDPH (Illinois Department of Public Health), the Illinois Breast and Cervical Cancer Program Lead Agency and HFS.
- Sending in this application does not guarantee that you will qualify for health insurance.
- You agree the state may seek reimbursement for services the state covered for you if those services should have been paid for by any other health coverage you may have.
- We will not share any information about immigration of any person who does not have an Alien Registration Number. We will verify your immigration status if you gave us your Alien Registration Number. To do that, we will check the number with the U.S. Citizenship and Immigration Service (USCIS). We may send other information to USCIS, such as copies of proof you sent of an Alien Registration Number and your Social Security Number, if you have one.
- If HFS pays medical bills for you, you give your right to collect medical support payments to the State of Illinois.
- Anyone who knowingly misuses the HFS MediPlan card may be committing a crime.
- The Illinois Breast and Cervical Cancer Program must collect information about persons who apply. This information may include your age, income, insurance status and diagnosis. This information may be used by IDPH and HFS to report statistics about persons who get services from the program. Your name will not be used in these reports.

I declare under penalty of perjury that I have read all statements on this form and the information I give is true, correct and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information.

Applicant's signature _____ **Date** _____
(Make a mark and have another adult sign next to your mark if you cannot sign your name.)

If someone completed this application on behalf of the Applicant, please complete the following and sign.

Name (print) _____ Signature _____

Date _____ Phone ( ) _____ Relationship to the applicant? _____

Applicant's Checklist

- ✔ Did you answer all the questions in Section 2?
- ✔ Did you sign and date Section 2?
- ✔ Do you have copies of all the proofs we said you would need?
- ✔ All the information that needs proof is marked with a star. ☆
- ✔ Take the completed application with copies of all proofs to your medical provider's office.

Next Steps

- Your medical provider must answer the questions in Section 1 and sign and date Section 1.
- Your medical provider must send both Section 1 and Section 2 to the IBCCP (Illinois Breast and Cervical Cancer Program) Lead Agency that serves your county/community.
- The IBCCP Lead Agency will review the application. If something is missing, the Lead Agency will let you or your medical provider know what else must be sent.
- If you meet the age, income, insurance status and diagnosis requirements for health insurance, the Lead Agency will notify you and your medical provider. The Lead Agency will also send your application to HFS (Healthcare and Family Services).
- If you do not meet the age, income, insurance status and diagnosis requirements for health insurance, the Lead Agency will notify you and your medical provider. The Lead Agency will send your application packet back to your medical provider. If this happens, talk to your medical provider about other options you may have.
- HFS will review your application as quickly as possible to make the final decision about whether you qualify for Health Insurance for Persons with Breast or Cervical Cancer.
- HFS will send you a notice to tell you, your medical provider and the Lead Agency if you qualify for health insurance. If you do not qualify, the notice will tell you why.

Other Important Information

If you are not satisfied with the actions taken on this application by HFS, you have the right to a fair hearing. You can ask for a fair hearing by calling 1-800-435-0774 (TTY: 1-800-435-1774 or 1-312-793-2697). **Use these numbers only to ask for a fair hearing.** You can also ask for a fair hearing by writing to Healthcare and Family Services, Bureau of Administrative Hearings, 401 South Clinton St., 6th Fl, Chicago, IL 60607.

You may qualify for other Illinois health insurance programs. Visit www.health.illinois.gov for more information.

If you have income from child support or Social Security, if there is a stepparent in your home, if you have high medical bills, or you have a disability that keeps you from working, you or your family may qualify for one of these other programs. You may apply for them at your Department of Human Services, Family and Community Resource Center (FCRC). To find the FCRC serving your community, call 1-800-226-0768. If you use a TTY, call 1-877-204-1012. The call is free. You can also find the office near you at www.dhs.state.il.us/officeLocator/. **If you apply for Health Benefits for Persons with Breast or Cervical Cancer, please do not apply again until we tell you our decision.**

Health Benefits for Persons with Breast or Cervical Cancer is open and accessible without regard to sex, race, disability, national origin, religion or age except as allowed by law. The State of Illinois is an equal opportunity employer that practices affirmative action. The State of Illinois provides reasonable accommodations according to section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

Section 3 – To be completed by the IBCCP Lead Agency/Consortium Agency. *Please print.*

Patient Name	Date of Birth

Date Referral Received	Date Referral Submitted to HFS Breast and Cervical Cancer Eligibility Unit

Lead/Consortia Agency Name

Lead/Consortia Agency Telephone	Lead/Consortia Agency Fax
( )	( )

Lead Agency name if referral is from a Consortia Agency.

The applicant meets the following IBCCP criteria for referral to HFS:

- Age;
- Resident of Illinois;
- Uninsured, including not having FamilyCare or other HFS medical coverage;
- Family income less than or equal to 250 percent of the Federal Poverty Level; and
- Diagnosed with breast or cervical cancer or one of the specified precancerous cervical conditions as supported by pathology report submitted.

Please review the pathology report and enter the date the applicant was screened and found to need treatment for breast or cervical cancer or precancerous cervical condition. This is the date of the diagnostic test or surgery that resulted in the qualifying diagnosis.

_____
Date

_____ _____
Signature of IBCCP Agent Date

_____
Printed Name of IBCCP Agent

Submit Sections 1, 2 and 3 of the application completed and signed along with copies of proofs required to:

HFS Breast & Cervical Cancer Eligibility Unit
P.O. Box 19122
Springfield, IL 62794-9122